STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G013	A. BUILDING _____ B. WING _____	C 09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY CAMPBELL CENTER	4641 WELDIN RD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from September 19, 2011 through September 22, 2011. The deficiencies contained in this report are based on observation, interviews and review of clients' records and review of other facility documentation as indicated. The facility census the first day of the survey was sixty-four (64). The survey sample totaled ten (10) clients and two (2) sub-sampled client for observations.	W 000		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on record review, interviews, and review of facility's policies, it was determined that the facility failed to provide the necessary treatment and services to one (C3) out of 10 sampled clients who had a pressure ulcer (PU). The facility failed to accurately and thoroughly assess C3's PU when C3 was readmitted to the facility. In addition, the facility failed to reassess the interventions to relieve pressure in the lumbar area. These failures resulted in a deterioration of the ulcer to an unstageable PU with eschar (dead tissue that falls off from healthy skin). Findings include: C3 was readmitted from the hospital on 8/19/11 with diagnosis of pneumonia. C3 was originally admitted to the facility on 10/16/2000 with diagnoses including cerebral palsy, seizure disorder, adjustment disorder with depressed	W 339	The Director of Nursing or designee will review the medical records of residents who have been admitted or re-admitted to the Center within 72 hours of return to ensure that assessment has been completed. Any identified deficient practice will be reviewed with the primary nurse immediately to ensure compliance. The "Pressure Ulcer Risk and Assessment" (Attachment C) and "Wound Assessment, Documentation and Notification" (Attachment C1) policy and procedures have been revised. All licensed nursing staff will receive training on these policies and procedures by November 15, 2011. A review of compliance (Attachment C3) with the "Pressure Ulcer Risk and Assessment" policy and procedures will occur at the quarterly Quality Assurance Committee meeting to ensure that the standards are being met.	10/14/11 10/14/11 11/15/11 11/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 10/14/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 339	Continued From page 1 mood, osteopenia, incontinence and had a replacement of a Baclofen (muscle relaxer and an antispastic agent) pump on 8/3/11. Review of nurse's note (N.N.) dated 8/19/11 timed 8 PM documented that C3 was noted to have reddened area of lumbar spine (6 centimeter/cm. in Length/L and 2 cm. in Width/W). The note documented that C3 was being repositioned every two hours to prevent any breakdown. Review of the facility's policy titled "Wound Assessment, Documentation, and Notification" indicated that upon identification of any type of alteration in skin integrity, the nurse discovering the information will begin the wound documentation and the notification process. The notification process included: a. Initiate the "Weekly Wound Healing Assessment" form. Initial documentation of the alteration in skin integrity will be recorded on this form. b. Address this new wound in the Resident's Health Care Plan. c. Notify the Resident's primary physician. d. Notify the Resident's guardian. e. Notify the "Wound Care Nurse." Although C3 had an area of alteration in skin integrity, a stage I PU as documented in the above N.N., record review lacked evidence that the facility initiated the notification processes as indicated in the above policy. An interview with E2 (Acting Director of Nursing) on 9/22/11 at approximately 10 AM confirmed that the facility failed to accurately and thoroughly assess the stage I PU of the lumbar area, failed to follow the	W 339		

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W 339	Continued From page 2 policy to implement the care plan and failed to notify the physician, guardian, and the wound care nurse. E2 related that during this period of time, there was not a designated wound care nurse. Review of August 2011 Treatment Record (TR) documented beginning on 8/20/11 3 PM-11 PM shift, that the "MCC/Mary Campbell Center protocol" to lower back twice a day was initiated until healed. This treatment continued twice a day through 8/30/11. Review of "Standing Order" for "abrasions, skin tear, and minor laceration" noted to cleanse area with normal saline, pat dry, apply petroleum jelly and cover with dry dressing. In addition, if the wound does not heal by the seventh day or worsens, to contact the resident's physician's for further orders. Record review lacked documentation that the physician was notified that the lumbar wound did not heal by the seventh day. Additionally, beginning on 8/29/11, duoderm (occlusive and adhesive wafer dressings which combine absorbent colloidal materials with adhesive elastomers to manage light to moderately exuding wounds) was applied to mid back area and changed twice on 8/29/11 and once on 8/31/11. Record review lacked an assessment of this area when the duoderm was being applied and no order was present for this intervention. On the September 2011 TR, it was noted that the duoderm was discontinued on 9/4/11. Subsequent N.N. dated 9/5/11 timed 3:20 PM documented a late entry for 9/4/11 at 11:50 PM in which a convex area of brown eschar was noted	W 339		

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W 339	Continued From page 3 in the lumbar region of C3's back. The note documented that the 11 PM-7 AM Nursing Supervisor observed the area and that the facility's wound care nurse would be notified. N.N. dated 9/6/11 timed 8:35 AM by E3 (Registered Nurse, Clinical Care Coordinator/Wound Care Nurse) documented a 7 cm. L by 3 cm. lumbar area PU covered with black eschar. An interview with E3 on 9/21/11 at approximately 1 PM revealed that she was newly designated as the wound care nurse on 9/6/11 and assessed C3's wound on the same day. On 9/6/11, E6 (Physical Therapist/P.T.) was consulted and the lumbar seat back was modified and the device which led to the lumbar PU was immediately removed. Review of the P.T. progress note dated 9/20/11 documented that the adjustment to C3's Baclofen pump resulted in considerable decrease in tone of the body, thus, adjustments were made to C3's wheelchair including the seat back to decrease pressure to the lumbar area. Findings reviewed with E1 (Administrator) and E2 (Acting Director of Nursing) on 9/22/11 at approximately 2 PM.	W 339		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to administer medications as ordered for one (SSC1) client observed during the medication pass. Findings include:	W 369	Employee E5 was counseled regarding the deficient practice. A Medication Error Report is completed by any nurse found to have made a medication error. Previous medication error records were reviewed and there were no trends identified exhibiting similar deficient practices. The Staff Educator will conduct training for the nursing staff to review the basics of medication administration. This will be completed within 30 days.	9/25/11 11/15/11

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W 369	Continued From page 4 During medication administration observation on 9/21/11 at 10 AM, E5 (Registered Nurse) administered one drop of Refresh Plus (eye lubricant) to SSC1's right and left eye. Review of the September 2011 Physician's Order revealed that the order was for two drops per eye four times a day. An interview with E5 on 9/21/11 at approximately 1:30 PM confirmed that the second drop was not administered to each eye as ordered. Findings reviewed with E1 (Administrator) and E2 (Acting Director of Nursing) on 9/22/11 at approximately 2 PM.	W 369	Medication Pass Observation Audit (see Attachment D) will be conducted monthly on every shift by the Director of Nursing or designee to assess the nursing staff's ability to safely administer medications. Any identified deficient practice will be reviewed with the nurse immediately to ensure compliance. There will be a review of the medication errors at quarterly Quality Assurance Committee meeting. At that time, we will discuss the number and errors and type, identify any trends, review follow-up training records and the need for additional training.	11/15/11 11/15/11
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on interview and review of facility's policy, it was determined that the facility failed to ensure that their infection control policy and procedure incorporated the standard practice for hand hygiene after removing gloves. In addition, based on observation and interview, it was determined that the facility failed to decontaminate hands in between changing of gloves. Findings include: 1. Review of facility's policy titled "Non Sterile Dressing Change" documented the following procedure which failed to include the standard of decontaminating hands after removal of gloves: 8. Don clean gloves.	W 455	Employee E3 was counseled regarding the deficient practice. The "Non-Sterile Dressing Change" policy and procedures were revised (Attachment E). The Wound Care Nurse was apprised of the change in protocol. A copy of the revised "Non-Sterile Dressing Change" Policy and Procedure will be placed in the Treatment Administration Record (TAR) and all licensed nurses will receive training on the revised policy within 30 days.	9/25/11 11/15/11

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W 455	Continued From page 5 9. Removed soiled dressing. 10. Don clean gloves. 2. During dressing change observation on 9/21/11 at approximately 9:50 AM, E3 (Registered Nurse) changed gloves three times without decontamination of her hands. Interview with E4 (Staff Educator) on 9/22/11 at approximately 1:30 PM confirmed that the above policy failed to include decontamination of hands after removal of gloves. Findings reviewed with E1 (Administrator) and E2 (Acting Director of Nursing) on 9/22/11 at approximately 2 PM.	W 455	Non-Sterile Dressing Change audits (Attachment E1) will be conducted monthly by the Director of Nursing and/or designee to assess the compliance by nursing staff with said policy and procedures. Any identified deficient practice will be reviewed with the nurse immediately and corrected to ensure compliance. Results of the Non-Sterile Dressing Change audits will be compiled and data shared at the quarterly Quality Assurance Committee meeting. The Committee will review the number and type of errors, identify any trends and the need for additional training if indicated.	11/15/11 11/15/11

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: The Mary Campbell Center

DATE SURVEY COMPLETED: September 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from September 19, 2011 through September 22, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was sixty-six (66). The survey sample totaled 10 clients and two (2) sub-sampled clients for observation in the ICF/MR sample. Additionally one (1) nursing home resident was reviewed for a complaint.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission**	

Provider's Signature _____ Title ADMINISTRATOR Date 10/13/11

NAME OF FACILITY: The Mary Campbell Center **DATE SURVEY COMPLETED:** September 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	are hereby adopted and incorporated by reference. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 9/22/11, W339, W369 and W455. **16 HEALTH AND SOCIAL SERVICES DELAWARE ADMINISTRATIVE CODE 14** **3201.7.5** **Kitchen and Food Storage Areas** **3201.7.5.1** **Facilities shall comply with the Delaware Food Code.** **3-303.11 Ice Used as Exterior Coolant, Prohibited as Ingredient.** **After use as a medium for cooling the exterior surfaces of food such as melons or fish, packaged foods such as canned beverages, or cooling coils and tubes of equipment, ice may not be used as food.** **This requirement was not met as evidenced by:** Based on observation of food handling during meal service on 9/21/11, it was determined that the facility failed to properly store and handle ice for consumption. Findings include: During a breakfast meal observation in the Farmhouse Lane dining room on 9/21/11 at approximately 9:15 AM, SSC2 asked for	A new Policy and Procedure (**Attachment B**) was developed and is now in effect regarding the proper use and handling of ice that is ingested during meals. All Food Service, Staff Nurses, and Activities Staff will receive training in the proper use and handling of ice used for consumption. All to be completed by 11/10/11. Quality Assurance- The Food Service Manager will perform random audit inspections of the meal service to determine that the policy and procedure is being followed correctly and, if not, to take corrective measures with any staff not in compliance. **Attachment B1** is a sample of the audit tool that will be used for this purpose. Audits will be conducted 3 times weekly for the first 60 days following initiation and 1 time weekly for the next 60-120 days and 1 time monthly thereafter. Results will be shared and discussed at the quarterly Quality Assurance Meeting to ensure that standards are being met.

NAME OF FACILITY: The Mary Campbell Center

DATE SURVEY COMPLETED: September 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	ice in the tea beverage that he was consuming. The kitchen had provided a metal tray with various beverages including; milk, yogurt, and applesauce in soufflé cups, that were placed directly in ice for cooling purposes. By 9:15 AM, the ice in this container had melted and food items were sitting in an ice/water slurry. E7 (dietary staff member) using his gloved hand removed ice from this container and placed the ice in the resident's cup and returned the cup to the resident. Ice used for cooling purposes may not be used as food. **3-303.12 Storage or Display of FOOD in Contact with Water or Ice.** **(A) PACKAGED FOOD may not be stored in direct contact with ice or water if the FOOD is subject to the entry of water because of the nature of its packaging, wrapping, or container or its positioning in the ice or water.** **This requirement was not met as evidenced by:** Based on observations, it was determined that the facility failed to prevent the contact of ice and water with cooling, packaged food. Findings include: 1. Observation of medication cart in Charmie Lane on 9/21/11 at 11:25 AM, pudding and applesauce cups were observed to be lying in a tub with an ice and water mixture. The packaging of the food was such that it could not prevent the entry of	A new product (Item 85232- colander insert and Item 26CW 6" deep ½ size food pan)) has been purchased that will replace what has been used to contain ice used as a coolant for packaged food products. The new product which has a drainage tray suspended one inch from the bottom of the container and allows for water formed by melting ice to be drained away from the ice itself and the packaged food products being cooled by the ice thus preventing the products from coming into contact with the water. All Dietary and Nursing staff will receive training on the proper use and handling of ice used in cooling food products and will follow the established Policy and Procedure (**Attachment A**) for the storage or display of food in contact with water or ice. All to be completed by 11/10/11.

NAME OF FACILITY: The Mary Campbell Center

DATE SURVEY COMPLETED: September 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	water into the packaging. 2. Observation of medication cart in the nursing station on 9/22/11 at approximately 12 noon revealed drinks lying in tub of water mixture. 3. Observation of medication cart in Farmhouse Lane on 9/21/11 at approximately 9:30 AM revealed drinks lying in tub of water mixture.	Quality Assurance- The Food Service Manager and Assistant Director of Nursing will perform random audit inspections of the meal service and med pass respectively to determine that the policy and procedure is being followed correctly and, if not, to take corrective measures with any staff not in compliance. **Attachment A1** is a sample of the audit tool that will be used for this purpose. Audits will be conducted 3 times weekly for the first 60 days following initiation and 1 time weekly for the next 60-120 days and 1 time monthly thereafter. Results will be shared and discussed at the quarterly Quality Assurance Meeting to ensure that standards are being met.